3 Hospice Guidelines

3.1 Introduction

3.1.1 General Policy

This section covers all Medicaid services provided by hospice facilities as deemed appropriate by the Department of Health and Welfare. It addresses the following:

- Medicare election.
- Required prior authorization (PA).
- Election period.
- Physician certification.
- Hospice election notification.
- Physician services.
- Reporting requirements.
- Electronic and paper claim billing.
- Claims payment.

Note: Hospice services are covered for Medicaid Enhanced Plan participants.

3.1.2 Participant Eligibility

To be eligible for hospice services, a participant must:

- Be enrolled in the Medicaid Enhanced Plan.
- Have physician certification that the participant's life expectancy is six months or less.
- Have signed a notice of election for hospice care.

If the participant is enrolled in Healthy Connections (HC), a referral is required from the participant's primary care physician (PCP).

3.1.3 Medicare Providers

All hospice agencies must apply for and receive a Medicare provider number before applying to the Idaho Medicaid Program for a provider number. A provider's enrollment in the Idaho Medicaid Program is separate from its Medicare application.

3.1.4 Advance Directives

When accepting a participant in the Hospice Program, the hospice provider must:

- Explain to the participant and the participant's family or caregiver that all services (doctor visits, pharmacy, etc.) will be coordinated with the hospice program.
- Explain to the participant their right to make decisions regarding their medical care, including the right to accept or refuse treatment.
- Inform the participant of their right to formulate advance directives, such as a Living Will or Durable Power of Attorney for health care, at the time the participant initially receives hospice care.

3.1.5 Hospice Participants Residing in Nursing Homes or Intermediate Care Facility (for Developmentally Disabled)/Mentally Retarded (ICF/MR) Facilities

3.1.5.1 Participant Liability

Medicaid participants residing in a nursing facility, who have elected the Medicare or Medicaid hospice benefit, must contribute toward the cost of their hospice care. The amount of each participant's liability (the contribution toward the cost of care) will be determined under the same rules that are currently applied to all other Medicaid nursing facility residents. Medicaid hospice participants will be notified when they must pay a contribution, or participant liability amount, toward the cost of their hospice care. Check with the participant or responsible person to determine whether the participant has a contribution.

Enter Value code **31** and the amount of participant liability in the Value Code field of the paper or electronic claim form. The Value Code field is found in field **39** on the UB-04 paper claim form, and under the Header Tab #4 in the PES electronic claim form.

3.1.5.2 Agreements between Hospice Agencies and Nursing Facilities

A written agreement should be developed by the hospice agency that explains the hospice provider's professional management responsibilities for the individual's hospice care and the facility's agreement to provide room and board to the individual. Hospice agencies will receive 95 percent of the nursing home daily rate for the nursing facility providing room and board to the hospice participant. The hospice agency is then responsible to reimburse the facility for the room and board payment. The participant liability amount should be indicated on the hospice claim form when billing for the nursing home room and board.

3.1.6 Payment

3.1.6.1 Healthy Connections (HC)

Check eligibility to see if the participant is enrolled in HC, Idaho's primary care case management (PCCM) model of managed care. If a participant is enrolled, there are certain guidelines that must be followed to ensure reimbursement for providing Medicaid-covered services. See *Section 1.5 Healthy Connections (HC), General Provider and Participant Information.*

3.1.6.2 Customary Fees

All hospice providers are paid through the use of five predetermined rates for rural or urban providers. Hospice-based physician employee services are billed by the hospice provider on the UB-04 claim form using revenue code **657** and the appropriate CPT procedure codes. Physicians not employed by the hospice must bill independently for their services.

3.1.6.3 Covered Services

All services related to the terminal illness are included in the prospective rates paid. The following services are included in the reimbursement rate:

- Nursing care.
- Physician services.
- Medical social services.
- Counseling services.
- Durable medical equipment.
- Supplies.
- Self-help and personal-comfort items.
- Home health and homemaker services.
- Physical, occupational, speech, and language therapy.

- Medication that is used primarily for the relief of pain and symptom control related to the terminal illness.

3.1.6.4 Restrictions

The hospice provider is responsible for providing up to 45 minutes daily of personal care services that are related to the terminal illness. Payment for this service is included in the hospice care daily rate.

Medicaid personal care services (PCS) may be authorized to provide routine personal care services that are **not** directly related to the individual's terminal illness. Medicaid PCS services may not be substituted for the primary care described above that is required by the hospice provider.

The hospice provider is responsible for services and items related to the terminal illness that another provider renders. Services and supplies not related to the terminal illness for pre-existing conditions are to be billed by the provider rendering the service, not under the hospice provider number.

Example: Reimbursement for treatment for the alleviation of cancer symptoms is included in the prospective rates paid to a hospice provider. Conversely, if the participant has a pre-existing chronic disease (*e.g.* diabetes), the diabetic services are reimbursed separate from the hospice services.

3.1.7 Authorization

An authorization is required for any participant electing Hospice services. When the participant has other insurance as the primary payer, the provider is still required to obtain prior authorization (PA) from the Medicaid Medical Care Unit. The Centers for Medicare and Medicaid Service (CMS) require a hospice agency to notify Medicaid when an individual, who is a Medicare beneficiary, elects or revokes the hospice benefit.

The requesting hospice provider should submit the following documentation to DHW within five working days:

- The completed DHW Hospice Intake form.
- The hospice election form signed by the participant or legal representative.
- The attending physician's history and physical.
- The hospice agency's completed Plan of Care (POC), signed by the physician.
- The physician's signed certification stating the individual's medical prognosis for life expectancy is six months or less.

The hospice POC and the physician's certification is to be signed by the physician within two calendar days of the election of the hospice benefit.

If the participant is enrolled in HC, a HC referral number is required from the participant's PCP.

All claims, both paper and electronic, **must** have the HC referral number listed on the claim.

Form available: The Hospice Intake form is included in *Appendix D; Forms*. Copies can be made as needed by the provider.

http://www.healthandwelfare.idaho.gov/portal/alias__Rainbow/lang__en-US/tabID__3438/DesktopDefault.aspx

3.1.8 Third Party Recovery (TPR)

See *Section 2.4 Third Party Recovery*, *General Billing Information,* regarding DHW policy on billing all other third party resources before submitting claims to Medicaid.

3.2 Hospice Service Policy

3.2.1 Overview

The Hospice Program is designed to keep the participant comfortable, free of pain, and in the least restrictive environment possible while providing services that are reasonable and necessary for the management of a terminal illness and related conditions.

This is strictly an elective program; a participant may elect or revoke hospice services at any time during the benefit period. The hospice provider may not coerce or prevent a participant's termination of election. The participant must acknowledge the waiver of other Medicaid benefits and the purpose of hospice care, in writing, in order to receive hospice care.

Note: Hospice services are covered for Medicaid Enhanced Plan participants.

3.2.1.1 Medicare Primary

If an individual is eligible for Medicare as well as Medicaid, the hospice benefit must be elected or revoked simultaneously under both programs.

3.2.2 Election Period

An election period, as identified in *IDAPA 16.03.10.451.06 Hospice – Definitions; Election Period* is any calendar month, or portion thereof, that hospice is elected. There are eight election periods allowed within the hospice benefit period. Each election counts as a calendar month within the benefit period. They are deemed to run consecutively unless revocation of an election has been made by the participant. An election period consists of any month or portion of a month a participant elects to receive hospice care.

Participants who have used their eighth month period and wish to extend their hospice election period may do so by not revoking their hospice election after the eighth month **and** requesting an extension from the Medicaid Medical Care Unit. No extension is available if the participant has revoked their hospice election in the last month.

3.2.3 Physician Certification

The hospice must obtain a physician certification statement, reflecting a prognosis of life expectancy of six months or less, no later than two calendar days after the participant chooses hospice care.

Fax a copy of the physician certification to:

Medical Care – Hospice
Fax: (208) 332-7280

3.2.4 Hospice Election Notification

When a participant elects hospice services, the hospice provider will notify DHW within five working days by faxing the required information on the intake form. This form is included in *Appendix D; Forms* of this handbook.

FAX the Hospice Election Notification to:

Medical Care – Hospice
Fax: (208) 332-7280

3.2.5 Hospice Revocation

When a participant elects hospice services, the hospice provider will notify the Medical Care Unit within five working days by faxing the required information on the intake form. This form is included in *Appendix D; Forms.*

Fax the Hospice Election Notification to:

Medical Care - Hospice
Fax: (208) 332-7280

3.2.6 Physician Services

The hospice agency must notify the Medical Care Unit of any changes in physicians who are employees, contractors, or volunteers of the hospice agency.

In addition, when the hospice agency submits the information requesting the hospice benefit for an individual, the information should identify whether the physician is an employee, contractor, or volunteer of the hospice agency.

Physicians who render hospice services who are not employees, contractors, or volunteers of the hospice agency, must bill Medicaid directly. The claim form should indicate that they have no affiliation with the hospice agency.

3.2.7 Reporting Requirements

Hospice agencies must report any change in physician affiliation with the hospice agency to the Medical Care Unit.

Additionally, hospice agencies must report any change in status (election or revocation of hospice or death) to the Medical Care Unit for any participant who is Medicare and Medicaid covered within five working days.

3.2.8 Medicare Crossover

Hospice participants may be dually eligible for Medicare and Medicaid. When a dually eligible participant elects Medicare hospice, a copy of the Notice of Election must be sent to the Medical Care Unit.

Medicare hospice claims will not automatically crossover from Medicare to Medicaid. Claims must be either billed on paper with the Medicare EOB attached, or electronically if your software supports it. See *Section 2.5 Crossover Claims*, *General Billing Information***,** for more information.

The hospice provider should first bill Medicare for rendered services. Medicaid pays for the coinsurance related to drugs and respite care on the Medicare claim. Medicaid also pays the hospice for the room and board rate at 95 percent of the daily rate for dually eligible hospice participants residing in a nursing facility.

3.2.9 Type of Bill Codes

Enter the 3-digit type of bill code in field **4** of the UB-04 claim form or in the appropriate field of the electronic claim form.

138 Outpatient: Void/cancel of prior claim

811 Admit through Discharge

812 Interim, First Claim

817 Outpatient: Replacement of prior claim

Note: For Medicare Part A crossover claims only, use the following codes:

813 Continuing Claim

814 Last Claim

3.2.10 Statement Covers Period

The Statement Covers Period field identifies the beginning and ending service dates of the period included on the bill. Late or additional charges outside the scope of the span indicated should be billed on a separate claim form or adjustment request. Medicaid does not pay accommodation charges, or any fraction thereof, for the last day of hospice room occupancy when a participant is discharged under normal circumstances.

Although there is no reimbursement for the discharge day, enter that date on the claim form. This ensures that the hospice receives reimbursement for the last full day of accommodation. If a participant requires

extended hospice care and the hospice sends an interim claim, enter patient status code **30** in field **17** of the UB-04 claim form or in the appropriate field of the electronic claim form. This code explains the participant is still a patient and to reimburse the hospice for the last day on the claim.

Claims for three sequential interim bills would have the following sequential date and patient status format:

Claim Number	From Date	To Date	Participant Status	Days Billed
1	01/15/05	01/31/05	30	17
2	02/01/05	02/15/05	30	15
3	02/16/05	02/24/05	01	9

Enter the dates for statement covers period in field **6** of the UB-04 claim form or in the appropriate field of the electronic claim form.

3.2.11 Patient Status Codes

Use only the following codes in field **17** of the UB-04 claim form or in the appropriate field of the electronic claim form:

01 Discharged to Home

20 Expired

30 Still a Patient, Not Discharged

3.2.12 Occurrence Codes and Dates

Use one of the following codes in fields **31-34** on the UB-04 claim form with the date of occurrence or in the appropriate field of the electronic claim form:

24 Date Insurance Denied

25 Date Benefits Terminated by Primary Carrier

42 Date of Discharge

3.2.13 Hospice Revenue Codes

All hospice services are to be billed using one of the following unique, three-digit revenue codes. Other revenue codes will be denied. Enter the 3-digit revenue code in field **42** of the UB-04 claim form or in the appropriate field of the electronic claim form.

Service	Rev. Code	Description
Routine Care	**651**	Daily care provided for general hospice care.
Continuous Care	**652**	Care rendered during crisis conditions. Requires a minimum of eight hours. Hours are counted from midnight to midnight. This procedure must be billed using units of time in 15 minute increments. Partial blocks may be billed in 15 minute increments. Services must be provided by a registered or licensed practical nurse.
Inpatient Respite Care	**655**	Respite care is limited to five days per election period (calendar month) for each participant in an approved inpatient facility. Respite care may only be rendered in a licensed freestanding hospice or a qualified nursing facility.
General Inpatient Care (Non-Respite)	**656**	Participant care must be rendered in an approved inpatient hospital or freestanding hospice bed.

Physician Care	**657**	Hospice-employed physician services must be billed with the appropriate CPT procedure codes on each line for each service.
Room and Board Care	**658**	Room and Board reimbursement for a hospice participant only occurs when the participant has been approved for a level of care in a long-term care facility. Medicaid is always the primary payer of the hospice room and board charge. Per diems are paid for Medicaid or dually eligible hospice participants residing in a Medicare certified nursing facility. The reimbursement rate will be 95 percent of the nursing facility rate on file in which the hospice participant is a resident. The 9-digit Nursing Home provider must be submitted on the claim in field **80** of the UB-04 claim form or in the appropriate field of the electronic claim form. Any participant liability will be withheld from the total hospice payments.

3.3 Claim Billing

3.3.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

To submit electronic claims, use the HIPAA compliant 837 transaction.

To submit claims on paper, use original red UB-04 claim forms available from local form suppliers.

Note: All claims must be received within 12 months (365 days) of the date of service.

3.3.2 Electronic Claims

For PES software billing questions, consult the *Provider Electronic Solutions (PES) Handbook*. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software. See the General Billing Information Handbook, *Section 2*, for more information.

3.3.2.1 Guidelines for Electronic Claims

Provider Number: In compliance with HIPAA and the National Provider Identifier (NPI) initiative beginning May 24, 2008, federal law requires the submission of the NPI number on all electronic 837 transactions. Idaho Medicaid recommends providers obtain and register one NPI for each Medicaid provider number currently in use. It is recommended that providers continue to send both their Idaho Medicaid provider number and their NPI number in the electronic 837 transaction. Electronic 837 claims will not be denied if the transaction is submitted with both the NPI and the Idaho Medicaid provider number.

Detail lines: Idaho Medicaid allows up to 999 detail lines for electronic HIPAA 837 Institutional transactions.

Modifiers: On an electronic HIPAA 837 Institutional transaction, where revenue codes require a corresponding HCPCS or CPT code, up to four modifiers are allowed. On a paper claim, only two modifiers are accepted.

Revenue codes, which are broken into professional and technical components, require the appropriate modifier. For institutional claims, the **TC** modifier must be submitted.

Type of bill (TOB) codes: Idaho Medicaid rejects all electronic transactions with type of bill (TOB) codes ending in a value of six. Electronic HIPAA 837 Institutional transactions with valid type of bill codes not covered by Idaho Medicaid are rejected before processing.

Condition codes: Idaho Medicaid allows 24 condition codes on an electronic HIPAA 837 Institutional transaction.

Value, occurrence, and occurrence span codes: Idaho Medicaid allows 24 value, 24 occurrence, and 24 occurrence span codes on the electronic HIPAA 837 Institutional transaction.

Diagnosis codes
Idaho Medicaid allows 27 diagnosis codes on the electronic HIPAA 837 Institutional transaction.

National Drug Code (NDC) information with HCPCS and CPT codes:
A corresponding NDC is required to be indicated on the claim detail when drug related HCPCS or CPT codes are submitted.

Electronic crossovers: Idaho allows providers to submit electronic crossover claims for institutional services.

3.3.3 Guidelines for Paper Claim Form

3.3.3.1 How to Complete the Paper Claim Form

The following will speed claim processing:

- Complete all required areas of the claim form
- Print legibly using black ink or use a typewriter
- When using a printer, make sure the form is lined up correctly to facilitate electronic scanning
- Keep claim form clean; use correction tape to cover errors
- A maximum of 23 line items per claim can be accepted; if the number of services performed exceeds 23 lines, prepare a new claim form and complete the required data elements; total each claim separately
- You can bill with a date span (From and To Dates of Service) only if the service was provided every consecutive day within the span
- Be sure to sign the form in the correct field; claims will be returned that are not signed
- Do not use staples or paperclips for attachments; stack them behind the claim
- Do not fold the claim form(s);mail flat in a large envelope (recommend 9 x 12)

See *Section 3.3.3.3 Completing Specific Fields on a Paper Claim Form*, for instructions.

3.3.3.2 Where to Mail the Paper Claim Form

Send completed claim forms to:

EDS
PO Box 23
Boise, ID 83707

3.3.3.3 Completing Specific Fields on a Paper Claim Form

See *Section 3.3.3.4 Sample Paper Claim Form*, to see a sample UB-04 claim form with all fields numbered. Provider questions regarding hospice policy and coverage requirements are referred to: *IDAPA 16.03.10.450-459 Hospice – Hospice Cap On Overall Reimbursement.*

The following numbered items correspond to the UB-04 claim form. Consult the, Use column to determine if information in any particular field is required and refer to the, Description column for additional information.

Claim processing will be interrupted when required information is not entered into any required field.

Field	Field Name	Use	Description
1	Unlabeled Field	Required	Provider Name, Address, and Telephone Number: Enter the provider name, address, and telephone number. The first line on the claim form must be the same as the first line of the Remittance Advice (RA). **Note:** If there has been a change of name, address, phone number, or ownership, immediately notify Provider Enrollment, in writing, to update the Provider Master File.
3a	PAT. CNTL #	Desired	The patient's unique alpha-numeric control number assigned by the provider to facilitate retrieval of patient financial records.

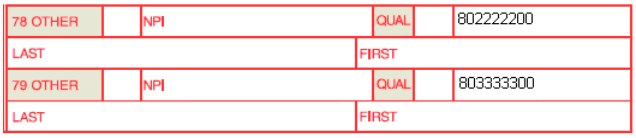
Field	Field Name	Use	Description
3b	MED REC #	Desired	Medical/Health Record Number: The number assigned to the participant's medical/health record.
4	TYPE OF BILL	Required	Type of Bill: Enter the 3-digit code from the *UB-04 manual*. Adjustment 'type of bill codes' are not appropriate when submitting services on paper claim forms for Idaho Medicaid billings. See *Section 3.1.4*, *Type of Bill Codes*.
6	STATEMENT COVERS PERIOD	Required	Statement Covers Period From/Through: The beginning and ending service dates of the period included on the bill. Enter as MMDDYY or MMDDCCYY **Administratively Necessary (AND):** The From date is the month, day, and year the participant was discharged from inpatient acute level of care. **Outpatient Claims**: Outpatient claims must indicate the specific dates in Field **45** to eliminate duplicate appearing services. **Late or Additional Charges:** **Inpatient** claims - see Field **42** for information. **Outpatient** claims - see Field **45** for information. **Accommodation Charges:** Medicaid does not pay accommodation charges, or any fraction thereof, for the last day of hospital room occupancy when a participant is discharged under normal circumstances. Although there is no reimbursement for the discharge day; that date should always be entered on the claim form. This ensures that the hospital receives reimbursement for the last full day of accommodation. **Extended Hospitalization:** If a participant requires extended hospitalization and the hospital decides to send an interim claim, enter patient status code **30** in Field **17**. This code tells the system that the participant is still a patient and to reimburse the hospital for the last day on the claim. Example*:* Claims for three sequential interim bills would have the following sequential date and patient status format: **Patient Days** **Claim / From / To Date / Status / Billed** 1 01/15-01/31/04 30 17 2 02/01-02/15/04 30 15 3 02/16-02/24/04 01 8 **Note:** If patient status **30** is not used, the accommodation rate formula will not balance and the system will deny the claim.
8a	PATIENT NAME - ID	Required	Enter the participant's 7-digit Medicaid identification number exactly as it is given in the Eligibility Verification System in this field. If your computer system demands an 11-digit MID, enter a zero in the eighth through the eleventh positions. Example: 0234567 can be entered as 02345670000.
8b	PATIENT NAME	Required	Patient Name: Enter the participant's name exactly as it is spelled on the participant's Medicaid ID card. Be sure to enter the last name first, followed by the first name, and middle initial.

Field	Field Name	Use	Description
12	ADMISSION DATE	Required, Inpatient, Hospice, Nursing Home	Enter the month, day, and year the participant entered the facility. (This date will be the same on all submitted claims and will not necessarily be the same as the date found in Field **6**. Enter as MMDDYY or MMDDCCYY
13	ADMISSION HOUR	Required, Inpatient, Outpatient, Hospice, Nursing Home	Enter the 2-digit hour the participant was admitted for inpatient or outpatient care in military time. Examples: Enter 01 for 1:00 a.m. Enter 10 for 10:00 a.m. Enter 22 for 10:00 p.m. Required for inpatient claims.
14	ADMISSION TYPE	Required, Inpatient	Admission Type: Use the priority admission codes in the *UB-04 manual*. Only codes **1**, **2**, **3**, and **4** are allowed by Medicaid. Required for inpatient claims.
15	ADMISSION SRC	Required, Inpatient	Admission Source: Use the 1-digit source of admission codes **1** through **8** in the *UB-04 manual*. Medicaid does not accept code **9**. Required for inpatient claims. Not Required for outpatient claims.
16	DHR	Required, Inpatient	Discharge Hour: Enter the 2-digit hour the participant was discharged in military time. Examples: Enter 01 for 1:00 a.m. Enter 10 for 10:00 a.m. Enter 22 for 10:00 p.m. Required for inpatient claims. Desired for outpatient claims.
17	STAT	Required, Inpatient	Patient Status: Use one of the codes listed in *Section 3.1.5, Patient Status Codes*, to indicate patient status. Required for inpatient claims. Not Required for outpatient claims.
18-28	CONDITION CODES	Desired	Use the codes listed in the NUBC billing manual.

Field	Field Name	Use	Description
31-34	OCCURRENCE CODE/DATE	Desired	Use one of the codes listed in the NUBC billing manual and enter the date of the occurrence.
35-36	OCCURRENCE SPAN	Desired	Use the date span related to the 'Occurrence Code' entered in the preceding field.
39-41	VALUE CODES AMOUNT	Required, AN Days	Value Codes and Amounts: See *Section 3.5, Billing Procedures*, for directions on how to bill AND. **Covered Days: Required for inpatient claims only** **80** – Covered Days **81** – Co-Insurance days (Cross over claims only) **82** – Lifetime Reserve Days (Cross over claims only
42	REV. CD.	Required, Inpatient	Revenue Codes: All revenues codes are accepted by Idaho Medicaid, however, not all codes are payable. **Revenue code 001** is no longer to be used for the total charges; the total charges are to be entered in the designated box on line 23. **Inpatient claims (late, additional, or denied charges):** 1. Late or additional charges where the revenue code was not on the original claim: Bill on a new claim for only the late or additional charges with the accommodation rate and revenue code**.** Note in the Field **80**, 'Billing for late charges'. 2. Late or additional charges where the revenue code was paid on the original claim: Submit an adjustment request form with the corrected information. 3. Bill for denied line(s) from the original claim: Bill the denied line with the accommodation rate and revenue code on a new claim. Note in the Field **80**, 'Billing for denied lines'. **Outpatient claims (late, additional, or denied charges):** For instructions for outpatients billing, refer to Field **45**.
44	HCPCS/RATE/ HIPPS CODE	Required, If Applicable	CPT/HCPCS/MODIFIERS/RATES: All accommodation codes require dollar amounts. CPT/HCPCS are required for all revenue codes with CPT or HCPCS notation in *Section 3.5.5, Revenue Codes* and *Section 3.7.3, Ancillary Revenue Codes*. If the code requires a modifier, put one space between the code and modifier. Example: PET scans require a HCPCS code and the **TC** modifier (i.e. G0222 TC). **Note:** HIPPS codes are not billable to Idaho Medicaid.

Field	Field Name	Use	Description
45	SERV. DATE	Required Outpatient	Service Dates: Required for all outpatient services. Enter the specific date of service for all charges or the claims will be denied. **Outpatient claims (late, additional, or denied charges):** 1. Late or additional charges outside the date span in Field **6**: bill on a new claim form. Note in the Field **80**, 'Billing for late charges'. 2. Late or additional charges within the date span in Field **6** with the same revenue codes and the same specific date: submit on an adjustment request form. 3. Late or additional charges within the date span in Field **6** with different revenue codes: bill on a new claim form. Note in the Field **80**, 'Billing for late charges' 4. Resubmit all denied charges on a new claim.
46	SERV. UNITS	Required	Units of Service: Enter the total number of covered accommodation days or ancillary units of service. Units of service for accommodations must correlate accurately to the service rendered. Example***:*** Accommodation Code = Number of days the level of service was rendered. **Note:** It is important to put the most appropriate rate next to the related code. Do not average charges for the same code. If a participant in the hospital receives three different levels of care, each must be billed on a separate line. Example***:*** Level I = $100 x 3 units of service Level II = $150 x 2 units of service Level III = $200 x 1 unit of service
47	TOTAL CHARGES	Required	Total charges: Bill total covered charges only. Ancillary Charges Formula: Revenue Code Fee X Units of Service Total Charges Accommodation Rate Formula: Daily Rate X Units of Service Total Charges
In Fields **50** through **62**, each field has three lines: A, B, and C. If Medicaid is the only payer, enter all Medicaid data on line A. If there is one other payer in addition to Medicaid, enter all primary payer data on line A and all Medicaid data on line B. If there are two other payers in addition to Medicaid, enter all primary payer data on line A, all secondary payer data on line B, and all Medicaid data on line C.			
50 A	PAYER NAME	Not Required	Payer A: If Medicaid is the only payer, enter *Idaho Medicaid* in Field **50A**. If there is one other payer in addition to Medicaid, enter the name of the group or plan in Field **50A** and enter *Idaho Medicaid* in Field **50B**.
50 B	PAYER NAME	Not Required	Payer B: If there are two other payers in addition to Medicaid, enter the names of the group or plan in Fields **50A** and **50B** and enter *Idaho Medicaid* in Field **50C**.
50 C	PAYER NAME	Not Required	Payer C: If there are two other payers in addition to Medicaid, enter 'Idaho Medicaid' in Field **50C**.

Field	Field Name	Use	Description
51 A-C	HEALTH PLAN ID	Not Required	Provider Number: Enter the 9-digit Idaho Medicaid provider number on the same line that Medicaid is shown as the payer. Enter the appropriate provider number for other insurance on the same line as that insurance is listed in Field **50 A-C**. Example: In Field **50A**, Medicare is entered as the Payer. In Field **51A**, enter the identification number used by Medicare for the provider. Example: In Field **50B**, Healthy Home Insurance Company is entered as the Payer. In Field **51B** enter the identification number used by Healthy Home Insurance Company for the provider.
54	PRIOR PAYMENTS	Required, If Applicable	Prior Payments - Payers and Participant: Required if any other third party entity has paid. Enter the amount the hospital has received toward the payment of this hospital bill from all other payers including Medicare. Do not include previous Medicaid payments.
55	EST. AMOUNT DUE	Not Required	Estimated Amount Due: Total charges due (total from Field **47**) minus prior payments (total from Field **54**).
57 A-C	OTHER (BILLING) PRV ID	Required	Provider Number: Enter the 9-digit Idaho Medicaid provider number on the same line that Medicaid is shown as the payer. Enter the appropriate provider number for other insurance on the same line as that insurance is listed in Field **50 A-C**. Example: In Field **50A**, Medicare is entered as the Payer. In Field **57A**, enter the identification number used by Medicare for the provider. Example: In Field **50B**, Healthy Home Insurance Company is entered as the Payer. In Field **57B** enter the identification number used by Healthy Home Insurance Company for the provider.
58	INSURED'S NAME	Desired	Insured's Name: If the participant's name is entered, be sure it is exactly as each payer uses it. For Medicaid, enter the name as it appears on the participant's Medicaid ID card. Be sure to enter the last name first, followed by the first name, and middle initial. Enter the participant Medicaid data in the same line used to enter the Medicaid provider data. Example: Medicaid provider information is entered in **50A**, and then the Medicaid participant data must be entered in **58A**.
59	P. REL	Desired	Patient's Relationship to Insured: See the *UB-04 Manual* for the 2-digit relationship codes.
60	INSURED'S UNIQUE ID	Not Required	Participant Identification Number: Enter the 7-digit Medicaid ID number exactly as it is given in the Eligibility Verification System in this field. If your computer system demands an 11-digit MID, enter a zero in the eighth through the eleventh positions. Example: 0234567 can be entered as 02345670000. Enter the identification number used by other payers on the appropriate line(s).
61	GROUP NAME	Not Required	Insured Group Name: If used, Medicaid requires the primary payer information on the primary/secondary payer line when Medicaid is secondary/tertiary.
62	INSURANCE GROUP NO.	Not Required	Insurance Group Number: If used, Medicaid requires the primary payer information on the primary/secondary payer line when Medicaid is secondary/tertiary.
63	TREATMENT AUTHORIZ-ATION CODES	Required, If Applicable	Treatment Authorization Codes: Prior authorization (PA) number for AND, or retrospective reviews or PA number for ambulance run by EMS.
67	DX A-Q	Required	Principal Diagnosis Code: Enter the ICD-9-CM code for the principal diagnosis. Do not use E diagnosis codes.

Field	Field Name	Use	Description
68-73	OTHER DX	Desired	Other Diagnosis Codes: Use the ICD-9-CM code(s) describing the secondary diagnoses. Do **not** use E diagnosis codes.
69	ADMIT DX	Required	Admitting Diagnosis Code: Required for inpatient. Desired for outpatient claims. Peer Review Organization (PRO) has designated specific V codes that are not appropriate as admitting diagnoses. Consult the *Qualis Health Handbook*.
72	ECI	Desired	External Cause of Injury Code: Enter the ICD-9-CM code for the external cause of an injury, poisoning or adverse effect. This code is to be used in addition to the principal diagnosis code and not instead of. (E codes are not used on the CMS-1500 claim form for professional claims.)
74	PRINCIPAL PROCEDURE CODE/DATE	Desired	Principal Procedure Code and Date: Enter the ICD-9-CM code identifying the principal surgical, diagnostic or obstetrical procedure. Procedure date is required if procedure code is used.
74 a-e	OTHER PROCEDURE CODE/DATE	Desired	Other Procedure Codes and Dates: Enter all secondary surgical, diagnostic or obstetrical procedures. ICD-9-CM coding method should be utilized. Procedure date is required if procedure code is used.
76	ATTENDING	Required	Attending Physician Identification Number: The Idaho Medicaid provider number is to be entered in the fourth (4^{th}) (last) box after '**76** Attending'. Inpatient: Enter the Idaho Medicaid provider number for the physician attending the patient. This is the physician primarily responsible for the care of the participant from the beginning of this hospitalization. Outpatient: Enter the Idaho Medicaid provider number for the physician referring the participant to the hospital.
78-79	OTHER	Required, Healthy Connect-ion	Other Physician Identification Number: The Idaho Medicaid provider number is to be entered in the fourth (last) box of **78** or **79** 'Other'. Required for Healthy Connections participants referred to the hospital by the primary care provider. Enter the primary care provider's 9-digit numerical referral number in Field **78** or **79**. Do not include the letters *HC* before the number. If Field **78** is blank the information in Field **79** will populate the referral number field. 
80	REMARKS	Not Required	Remarks: Enter information when applicable. For participants who have only Medicare Part A, enter *Participant has Part A only*. Other information to be entered may include: proof of timely billing ICN, third party injury information, or no third party liability coverage.

3.3.3.4 Sample Paper Claim Form